PRINTED: 08/14/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED	
NVS3662HIC				B. WING		03/20/2009	
COMPASSIONATE CARE			3882 CHUT	DDRESS, CITY, STATE, ZIP CODE  UTNEY STREET  GAS, NV 89121			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		(X5) COMPLETE DATE
H 000	Initial Comments			H 000			
	This Statement of Deficiencies was generated as a result of a State Licensure survey conducted at your facility on 03/20/09.						
	This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.						
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.  The census at the time of the survey was two (2) resident.  The following regulatory deficiencies were identified.						
			o (2)				
H 019	Director Duties-No F	ctor Duties-No FA/CPR		H 019			
	The director of a hom 4. Ensure that a care meeting the needs of trained in first aid, an	giver, who is capable of the residents and has d cardiopulmonary e premises of the home	f been				
	Based on observation review on 03/20/09,	ot met as evidenced by n, staff interview, and re the facility failed to ens s on the premises of th	ecord ure				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 08/14/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3662HIC 03/20/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3882 CHUTNEY STREET COMPASSIONATE CARE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 019 H 019 Continued From page 1 home at all times when a resident was present. and that evidence of training for the caregivers in first aid and cardiopulmonary resuscitation was available. Findings include: Observation: When the surveyor arrived at the facility at 2:30 PM there was no answer at the door. After several minutes of knocking, a person who stated that she was the owner/caregiver's sister, came from across the street and allowed the surveyor into the home. Interview with the sister indicated that the caregiver was at a "workshop". Two residents were in the home. Resident #1 appeared confused, was ambulatory, and per documentation on her file had a history of wandering away from the residence. Resident #2 was sleeping and according to the sister, bed bound and a hospice patient. Approximately 45 minutes after the surveyor arrived employee #1 returned to the facility. Interview: Interview with Employee #1 indicated that she had asked her sister to stay with the residents while she was away. The facility failed to ensure at least one (1) caregiver was on the premises of the facility when one (1) or more residents were present. Record Review:

PRINTED: 08/14/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3662HIC 03/20/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3882 CHUTNEY STREET COMPASSIONATE CARE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 019 H 019 Continued From page 2 The facility failed to provide evidence that Employee #1 and Employee #2 had CPR and First Aid training. H 055 H 055 Tuberculosis-Residents NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section. the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness;

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(5) Is experiencing night sweats;

has active tuberculosis.

(6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who

(b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or

PRINTED: 08/14/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3662HIC 03/20/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3882 CHUTNEY STREET COMPASSIONATE CARE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 055 Continued From page 3 H 055 home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3

weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the

PRINTED: 08/14/2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3662HIC 03/20/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3882 CHUTNEY STREET COMPASSIONATE CARE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 055 H 055 Continued From page 4 quidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.

7. The staff of the facility or home shall ensure that counseling and preventive treatment are

PRINTED: 08/14/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3662HIC 03/20/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3882 CHUTNEY STREET COMPASSIONATE CARE** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) H 055 Continued From page 5 H 055 offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 03/20/09, the facility failed to ensure that 1 of 2 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2). Findings include: Record Review: The facility failed to ensure that Resident #2, admit date 10/12/08, had a two-step tuberculin skin test within the 12 months preceding admission.